STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A109	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center	2335 S. Mountain Ave Duarte, CA 91010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was immediately provided with proper technique of Heimlich ' s maneuver (a procedure used to force a foreign object from a choking victim ' s airway [organ that allow airflow to the lungs] by performing an abdominal thrusts) and proper technique of cardiopulmonary resuscitation (CPR-a lifesaving emergency procedure for a victim who has signs of cardiac arrest [a situation when a victim becomes unresponsive, no normal breathing, and no pulse]), in accordance with the standard to practice the facility ' s policy and procedure of Emergency Procedure-Choking and Emergency Procedure-Cardiopulmonary Resuscitation. The facility failed to ensure: 1. The Program Counselor (PC 1) and PC 2, who observed Resident 1 showing signs of choking by holding his neck gasping for air walking down the hallway instructed Resident 1 to cough out while still awake and alert to help clear the resident ' s airway. 2. Resident 1 was immediately provided Heimlich ' s maneuver and immediately called for help when PC 1 and PC 2 observed the resident showed signs of choking by holding his neck gasping for air walking down the hallway on [DATE] at about 1:25 AM. Instead, PC 2 assisted Resident 1 who was weak and with difficulty breathing to walk thirty-seven (37) feet from his room to Nursing Station (NS) 1, before Certified Nurse Assistant (CNA) 7 performed Heimlich ' s maneuver to the resident. 3. Licensed Vocational Nurse (LVN) 2 does not perform a blind finger sweep (a procedure of running your finger through the choking person's mouth to dislodge the food or other object that is blocking the airway without visualizing the object to avoid further obstruction by pushing the object deeper in the throat and totally block the airway) without seeing any object or food in the mouth to Resident 1 ' s mouth twice after Resident 1 regained pulse and opened eyes. 4. Certified Nurse Assistant (CNA) 8 continued to perform chest compressions while Resident 1 had no pulse, was unconscious and not breathing. In contrast, CNA 8 placed the resident in a sitting position performing the Heimlich maneuver. 5. Resident 1 was provided rescue breaths (mouth to mouth breathing) or oxygen was delivered via Ambu bag (a hand-held device consists of inflatable bag attached to a face mask, used to deliver high concentrated oxygen to a victim with ineffective or absent breathing). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Actual harm Residents Affected - Few	6.The facility was supplied with an Automated External Defibrillator (AED, a device used to help victims experiencing sudden cardiac arrest [heart stop functioning], to help the heart re-establish an effective rhythm) available for access to assist in a cardiac arrest situation. 7. The facility staff announced Code blue (called when there is a medical emergency in the facility) in the facility ' s call system when Resident 1 was observed choking and became unresponsive. As a result of these failure Resident 1 continued to choke resulting in resident ' s loss of consciousness, loss of pulse and stopped breathing and pronounce dead by the paramedics (healthcare professional that respond to emergency calls and performs CPR to the victims) on [DATE] at 2:07 am due to cardiac and respiratory arrest (heart and lungs stopped functioning) related to asphyxia (the state or process of dying from not having enough air or unable to breathe). Findings: A review of Resident 1 ' s Admission Record, dated [DATE], indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), anxiety disorder (a condition being afraid of the unknown) and hypertension (high blood pressure). A review of Resident 1's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated [DATE], the MDS indicated, Resident 1 ' s cognitive skills for daily decision making was moderately impaired (decisions poor, cues/supervision required), needed supervision or touching assistance (the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity and assistance may be provided throughout the activity or intermittently) in eating. A review of the physician ' s order dated [DATE] indicated, Resident 1 was to receive Regular-NAS (No Added Salt diet with mechanical soft [any foods that can be blended, mashed, pureed]) chopped meat texture. A review of Resident 1 ' s Dietary Profile/Preferences, dated [DATE], indicated, Resident 1 was placed on mechanical soft/chopped meat for difficulties with chewing/swallowing due to some missing teeth, and Resident 1 usually had a snack between meals and preferred to snack at 8 pm. A review of Resident 1 ' s Blue Incident and Observation/ABC Report, dated [DATE], indicated Resident 1 had a choking incident on [DATE] with the onset time of 1:26 am in the corridor, which resulted in Resident 1 passing away on [DATE] at 2:07 am. A review of Resident 1 ' s Health Status Note, dated [DATE], timed at 5 am, written by Licensed Vocational Nurse (LVN) 2 indicated, At 1 :26 am, a PC 1, who was situated in the hallway near the resident's (Resident 1) room and saw the resident standing in the hallway and trying to cough out something .The Program Counselor and CNAs accompanied the resident to the hallway toward Station 1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s Health Status Note, dated [DATE], timed at 6:10 am, written by Registered Nurse Supervisor (RNS) indicated, At 1:30 am, PC 2 saw resident (Resident 1) coming out of his room trying to cough out something and holding his neck while walking towards Station 1 .Staff noted resident (Resident 1) choking .Charge Nurse did mouth sweep and took out 3 small pieces of bread. Resident (Resident 1) passed out and was laid on the floor. Staff called 911 and continued Heimlich ' s maneuver and mouth sweep with no foreign objects obtained. A review of the facility ' s investigation reportincluded Certified Nurse Assistant (CNA) 7 ' s written interview statement, dated [DATE], that indicated, While conducting rounds, observed resident (Resident 1) experiencing signs of choking and he performed Heimlich ' s maneuver. Despite the effort, Resident 1 collapsed, prompting a transition to the floor. Upon assessing Resident 1 ' s vital signs, it was noted that there was no palpable pulse. CPR was initiated; concurrently, the charge nurse assisted by clearing any obstruction in the resident ' s airway. A review of the facility ' s investigation report included the LVN 2 ' s written interview statement, dated [DATE], that indicated At 1:00 am to 1:25 am, resident was pacing back and forth in the hallway by Station 1. At 1:26 am, a PC (PC 1), who was situated in the hallway near the resident ' s (Resident 1) room, saw the resident standing in the hallway and trying to cough out something. At 1:30 am, Code Blue was called. The PC and CNAs accompanied the resident to the hallway towards Station 1. LVN and CNAs alternated doing Heimlich ' s maneuver. LVN did the finger sweep, nothing came out. The PC, CNA and LVNs guided resident to the floor in supine position (lying on the back). LVN did finger sweep and was able to get some small pieces of bread taken out from his throat. Resident became unresponsive, staffs put resident on the side to check if there are still some foreign objects then back to the supine position. CPR was initiated and oxygen was provided via nasal cannula .Then at 2:07 am, Deputy Sheriff pronounced the resident death due to cardiac arrest. A review of the facility ' s investigation report included CNA 8 ' s written interview statement, dated [DATE], timed at 1:30 AM, that indicated, on the way to the time clock for a break time, she observed CNA 7 asking another CNA to help. CNA 8 indicated she observed Resident 1 lying on the floor, she and CNA 7 rushed to Resident 1 and felt the resident without pulse; she then began chest compression. After several chest compressions, CNA 8 indicated she felt Resident 1 ' s pulse and opened his eyes, then closed again. Charge Nurse swept Resident 1 ' s mouth and some pieces of bread came out; CNA 8 indicated she felt for Resident 1 ' s pulse again, but felt there was no pulse, then chest compressions were restarted; then Resident 1 regained a pulse; then Resident 1 was nonresponsive again, Charge Nurse turned Resident 1 to his side. While Resident 1 was nonresponsive with no pulse, CNA 8 indicated she pulled Resident 1 in sitting position and while behind the resident, she performed the Heimlich ' s maneuver, but Resident 1 was still unresponsive. A review of the Paramedics report indicated the Fire Department received a 911 call from the facility on [DATE] at 1:30 a.m. for a resident that was chocking. The report indicated the paramedics arrived at the facility on [DATE] at 1:42 p.m. and CPR was provided at 1:45 am. Upon arrival Resident 1 was pale, warm, and apneic (periods of stop breathing) pulseless (no pulse) and without pupillary response (indicating no brain activity) and emergency care was provided. The paramedics report indicated food was removed from the airway via forceps (instrument used for grasping and holding object) and unable to remove possible remaining food. CPR was terminated at 2:06 a.m. and time of death was recorded at 2:07 a.m. due to cardiac and respiratory arrest related to asphyxia. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 1:45 p.m. with PC 1, PC 1 stated on [DATE], at around 1:25 am 1:30 am, he saw Resident 1 in front of his room walking so slowly and had one big loud cough, gasping for air while both of his hands were holding on to his neck. PC 1 stated, he knew how to perform Heimlich ' s maneuver by doing abdominal thrust, but he did not assist Resident 1 when he observed him chocking because he was watching another resident in another room, PC 1 stated Resident 1 was having difficulty talking and breathing, which was a significant sign for choking. PC 1 stated he called out to PC 2, who was walking behind Resident 1 to assist Resident 1. PC 1 stated he did not ask Resident 1 if he was choking and did not instruct nor encourage Resident 1 to continue coughing because Resident 1 was becoming weak and could not talk. During an interview on [DATE] at 1:55 p.m. with PC 2, PC 2 stated on [DATE], around 1:25 am, PC 2 saw Resident 1 stood up from a bench which was next to NS 1 and walked toward his room. When Resident 1 got close to his room ' s door, PC 2 was walking behind him and heard PC 1 telling her that Resident 1 was choking. PC 2 then yelled towards NS 1 for help. PC 2 stated, CNA 7 and CNA 9 came to assist, and PC 2 told them to help Resident 1 back to NS 1. PC 2 stated, Resident 1 was awake when he was assisted to NS 1 from his room. When Resident 1 got to NS 1, CNA 7 told LVN 2 about the choking situation and CNA 7 started Heimlich ' s maneuver. PC 2 stated, Resident 1 was very weak, stopped coughing and was having difficulty breathing. PC 2 stated the resident was still standing when CNA 7 started Heimlich ' s maneuver. PC 2 stated, CNA 7 performed Heimlich ' s maneuver before Resident 1 passed out, with face turned purple and sliding down onto the floor. PC 2 added, CNA 7 went to ask for help in the hallway and came back with CNA 8 who checked Resident 1 ' s pulse and started chest compression. During an interview on [DATE] at 4:33 p.m. with Registered Nurse Supervisor (RNS), RNS stated on [DATE], around 12 am, Resident 1 was in front of the Treatment Room and the resident asked her for food, but she didn ' t have food in NS 1, so she went to the other unit (NS 3) to get some food. RNS stated, when she brought back a cake to NS 1, Resident 1 was no longer in front of the Treatment Room. RNS stated, she did not look for Resident 1 ' s whereabouts because she thought Resident 1 went to bed and slept. During the same interview, RNS stated, at around 1:30 am, RNS received a call from LVN 2 who was in NS 1 informing her that there was an emergency. When RNS arrived in NS 1, she observed Resident 1, who was unconscious and pale, lying on the floor while CNA 7, and CNA 8 were performing chest compression on the resident. RNS stated she recalled LVN 2 doing finger sweep on Resident 1 and took out about three small pieces, about two centimeters (unit of measurement) in length, of what looked like peanut butter sandwich. RNS stated, when she checked Resident 1 ' s oxygen saturation (blood oxygen level in the blood) it registered as zero (normal oxygen saturation level ,d+[DATE]%). RNS stated, she brought the oxygen tank and administered oxygen to Resident 1 at a rate of six Liters (6L) per minute via nasal cannula (a plastic tube used to deliver oxygen to the nares). RNS stated, Resident 1 ' s oxygenation level remained at zero. RNS stated, she saw CNA 8 perform Heimlich ' s maneuver to Resident 1 while the resident was already unconscious. RNS added, CNA 8 performed about thirty (30) seconds of Heimlich ' s maneuver while having him in a sitting position and LVN 2 tried doing the finger sweep, but nothing came out. RNS stated, Code Blue was called by LVN 2. During an interview on [DATE] at 5:15 p.m. with CNA 1, CNA 1 stated CNA 1 didn ' t hear anyone call for a Code Blue over the facility ' s speaker system. CNA 1 stated Resident 1 had a habit of asking for food and was always hungry at night, but the charge nurses usually give Resident 1 snack at nighttime. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 6:30 a.m. with CNA 8, CNA 8 stated at around 1:30 am, as she got closer to NS 1, she saw CNA 7 ran in the hallway asking another CNA for help. Then CNA 8 saw Resident 1 laying on his back, unresponsive. CNA 8 stated she saw PC 1 with PC 2 standing close to Resident 1, not performing CPR and LVN 2 was in the NS 1 on the phone, calling 911(an emergency call system that alerts the police and fire department of the emergency situation). CNA 8 stated she went to help Resident 1, then, CNA 7 came back. CNA 8 stated she did not feel Resident 1 ' s pulse, so CNA 7 started chest compression. CNA 8 stated, after compression Resident 1 suddenly had a pulse, so CNA 7 stopped chest compression and tried to wake up Resident 1, but Resident 1 lost his pulse again. CNA 8 stated, she heard CNA 7 told LVN 2 to sweep his (Resident 1) mouth. CNA 8 stated, LVN 2 swept Resident 1 ' s mouth and a few pieces of bread smelling like peanut butter came out the resident ' s mouth. During the same interview, on [DATE] at 6:30 am, CNA 8 stated, after Resident 1 lost his pulse the second time, she took over chest compression, but Resident 1 continued to have no pulse. CNA 8 stated, she then sat Resident 1 up and tried to perform Heimlich ' s maneuver and LVN 2 turned Resident 1 on the side trying to hit Resident 1 ' s back, but nothing came out of the resident ' s mouth, and he continued to have no pulse. CNA 8 stated, she only helped Resident 1 with chest compression and did not observe Resident 1 receiving any rescue breaths or given oxygen via Ambu bag when they were trying to rescue Resident 1. CNA 8 stated, they should have an AED machine at the facility but there was no AED machine available in the facility. During an interview on [DATE] at 8 a.m., CNA 7 stated, at around 1:29 am, CNA 7 saw Resident 1 choking because he was holding his neck, he was weak, his face was pale. CNA 7 stated he saw PC 1 and PC 2 walking slowly behind Resident 1 going towards the NS 1, so he came to help the resident. CNA 7 stated, when Resident 1 walked close to the NS 1, he could not walk anymore, he could not talk and was too weak. LVN 2 was in the NS 1 and saw the resident, so she came out to help. CNA 7 stated, he told LVN 2 that Resident 1 was choking, and he immediately started Heimlich ' s maneuver. CNA 7 recalled that he did about ten (10) to fifteen (15) times Heimlich ' s maneuver, but Resident 1 was not good because while he was holding him and doing the Heimlich ' s maneuver, Resident 1 collapsed and lost consciousness. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During the same interview on [DATE] at 8 a.m., CNA 7 stated, while Resident 1 was unresponsive, he laid Resident 1 on the floor and went to the hallway asking for help from other CNAs while LVN 2 went to call 911. CNA 7 stated, he went to the hallway and saw CNA 8 who was about to go on break and CNA 8 came to help him with Resident 1. CNA 7 stated, when he returned with CNA 8 to Resident 1, they checked Resident 1 ' s pulse, but there was no pulse, so CNA 7 started chest compression. CNA 7 stated, when he did about thirty (30) times of chest compression, he and CNA 8 felt that Resident 1 had weak pulse with his mouth opened and trying to breathe so CNA 7 stopped chest compression. CNA 7 stated he tried to wake up Resident 1, while LVN 2 tried to sweep his mouth and CNA 7 recalled that a little bit of bread, or sandwich, white and brown in color, small pieces came out of Resident 1 ' s mouth, but Resident 1 lost his pulse again, so CNA 8 resumed chest compression. CNA 7 stated he was exhausted, so he did not continue to provide chest compression to Resident 1. CNA 7 stated, he saw that LVN 2 turned Resident 1 on his side and was sweeping Resident 1 ' s mouth with her finger but could not get anything out, so CNA 8 performed Heimlich ' s maneuver again to Resident 1, but Resident 1 remained unresponsive. CNA 7 stated CNA 8 resumed chest compression but the resident ' s pulse did not return and remained unresponsive. CNA 7 stated, during the rescue, he did not see any crash cart used, or any oxygen given to Resident 1, and did not recall a Code Blue was called over the speaker. CNA 7 stated, he only performed chest compression to Resident 1, no one provided rescue breaths, and he did not recall any AED was used for the resident. During the same interview on [DATE] at 8 a.m. CNA 7 stated, before the incident, Resident 1 was walking around in the hallway. Resident 1 usually asked for food because he was hungry all the time, even at night, and he would go to the charge nurse to get food like crackers. CNA 7 stated, the charge nurses usually provided snacks to the residents at night. During an interview on [DATE] at 9:16 a.m. with CNA 2, CNA 2 stated, he did not hear Code Blue called out on the speaker or by anyone in the facility on the early morning of [DATE] at approximately 1:30 a.m., when the incident with Resident 1 happened. During an interview on [DATE] at 9:26 a.m. with the Administrator (ADM), the ADM stated PC 1 and PC 2 were not CPR certified. ADM stated, PC 1 and PC 2 provides direct patient care to the residents and are responsible to monitor the residents ' behaviors and when residents are dining, so they should have been trained to do CPR or know what to do when the residents are choking. During an interview on [DATE] at 10 a.m., LVN 3 stated, there was no AED machine in the facility that could be used in an emergency. LVN 3 stated, when a resident was found choking, they should act right away. LVN 3 stated, when a resident was found unresponsive, the LVN should check the pulse and initiate chest compression right away. LVN 3 stated, CPR should be given with chest compression and rescue breaths per protocol and standard of practice. LVN 3 stated, when code blue happened, the facility does not have a form used to document what was done during the code. LVN 3 stated, all residents are given snacks at night if requested. During a concurrent observation and interview on [DATE] at 11:15 a.m. with the Director of Nurses (DON). The DON confirmed the distance between Resident 1 ' s room and the NS 1 was measured at 37 feet. The DON demonstrated in the presence of the surveyor that it would take more than 40 seconds to walk slowly from the front on Resident 1 ' s room to the Nursing Station 1. The DON stated, forty (40) seconds could be critical for a resident to walk who had difficulty with breathing. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 12:47 p.m. with LVN 2, LVN 2 stated on [DATE] at around 1:30 am, while sitting down charting in Nursing Station 1, LVN 2 stated she heard a commotion, and she saw CNA 7, PC 1, and PC 2 accompany Resident 1 walking slowly towards Nursing Station 1. LVN 2 stated, Resident 1 ' s face was pale, he was very weak, and his hands were just like hanging on his sides when she observed PC 1 and PC 2 holding on to the resident ' s arms assisting him to walk to NS 1. LVN 2 stated, PC 2 told her that It looked like he (Resident 1) is choking. LVN 2 stated, she saw CNA 7 performed Heimlich ' s maneuver on Resident 1 when the resident reached Nursing Station 1. LVN 2 stated while CNA 7 was doing Heimlich ' s maneuver she looked inside Resident 1 ' s mouth but could not see anything. LVN 2 stated, she then used her fingers to reach inside Resident 1 ' s mouth to the back of his throat and swept around to look for something inside the mouth, but she did not get anything out. LVN 2 stated, Resident 1 started to slide down and became unconscious and was assisted to lie down on the floor. LVN 2 stated, she and other staffs tried to call Resident 1 ' s name to wake him up but he was not moving and not responding. LVN 2 stated, she tilted (lifting a person ' s chin while pushing down the forehead to open the airway) Resident 1 ' s head and looked inside his mouth again but she could not see anything. LVN 2 stated, she then tried to reach inside Resident 1 mouth and swept around for the second time in the lower right side of the mouth close to the throat, and she was able to remove some pieces of bread which smelled like peanut butter. During the same interview on [DATE] at 12:47 p.m., LVN 2 stated, when Resident 1 was laid on the floor and already lost consciousness, she did not immediately perform chest compression. Instead, LVN 2 stated, she went to call 911. LVN 2 stated while calling 911, CNA 8 came by and was the first to check for Resident 1 ' s pulse and initiated chest compression after Resident 1 became unresponsive. LVN 2 stated, she saw RNS brought in an oxygen tank while the staffs were doing the chest compression and administered the oxygen to Resident 1 via nasal cannula (not via an Ambu bag). LVN 2 stated, she did not call out Code Blue over the speaker to alert the other staffs with the emergency. During an interview on [DATE] at 3:27 pm with the DON, the DON stated the facility Resident 1 was found choking from what looks like a peanut butter sandwich, which was obtained from his roommate who receives evening snacks. The DON explained, when a resident was choking, the charge nurse was supposed to assess the resident, and anybody could have acted immediately and helped when a resident was observed choking. The DON stated, she expected her staff to perform Heimlich ' s maneuver as soon as possible because it was a life-threatening situation when a blockage in the resident ' s throat could block the airway and the resident could not get oxygen. The PC should have immediately performed Heimlich ' s maneuver because it was a life-threatening situation. According to the investigation reported by the charge nurse LVN 2 performed the finger sweep on Resident 1 without seeing anything in the mouth, was not acceptable because it could increase the risk of pushing down the food further or whatever was blocking the airway and increase aiirway obstruction. DON stated, if the PCs were doing direct care to the residents, they should have been trained to do Heimlich ' s maneuver or CPR and be CPR certified. The DON stated, in a situation when a resident was not breathing, an Ambu bag should be used to deliver oxygen or be given rescue breaths. The DON stated, there should be an AED device in the facility to be used for emergency. The DON stated there was no documented evidence of the procedures performed by the staffs during the Code Blue situation or if the physician was informed about Resident 1 on [DATE] before Resident 1 died . (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	A review of Basic Life Support Provider Manual by American Heart Association, dated 2020,indicated: High-quality CPR with minimal interruptions and early defibrillation (administering a controlled electric shock to allow restoration of the normal rhythm.) are the actions most closely related to good resuscitation outcomes. High quality CPR if started immediately after cardiac arrest combined with early defibrillation can double or triple the chances of survival. These time-sensitive interventions can be provided both by members of the public and by healthcare providers. By standers who are not trained in CPR should at least provide chest compressions. Even without training, bystanders can perform chest compressions with guidance from emergency telecommunicators over the phone; the signs of severe airway obstruction included clutching the throat with the thumb and fingers, making the universal choking sign, unable to speak or cry, weak/ineffective cough or no cough at all, and the rescuer actions included: to take step immediately to relieve the obstruction, if severe airway obstruction continues and the victim becomes unresponsive, start CPR. A review of Basic Life Support Provider Manual by American Heart Association, dated 2020, indicated: a choking victim ' s condition may worsen, and the victim may become unresponsive. If the rescuer is aware that a foreign-body airway obstruction is causing the victim ' s condition, you will know to look for a foreign body in the throat. To relieve choking in an unresponsive adult, follow these steps: 1. Shout out for help. Send someone to activate the emergency response system. 2. Gently lower the victim to the ground if you see that they are becoming unresponsive 3. Begin CPR, starting with chest compressions. Do not check for a pulse. Each time you open the airway to give breaths, open the victim ' s mouth wide. Look for the object. 4. If you see an object that looks easy to remove, remove it with your fingers 5. If you do not see an object, continue CPR. 6. After about 5 cycles or 2 minutes of CPR, activate the emergency response system if someone has not already done so. A review of the facility ' s policy and procedure (P&P) titled, Dining room Protocol, dated [DATE] indicated, dining room will have two Program Staff always monitor both doors to ensure that no resident sneaks ' food out of the dining room. A review of the facility ' s undated, P&P titled, Codes, indicated, Code Blue is called when there is a medical emergency such as a heart attack or other medical emergencies. indicated the following: 1. Code Blue is defined as: The emergency management of a medical problem which requires intervention by a licensed nurse for immediate medical assessment and intervention. It is necessary that licensed nurses respond to code blue when called. 2. Code blue is announced by a staff, indicating the place (Room number, and/or Nursing station, patio, etc.) (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Actual harm Residents Affected - Few	3. Supervisor will direct each member assigned in the team to a specific function to assist in the care of the resident. CNA and any other staff maybe assigned to obtain necessary equipment/supplies. Continuous assessment must be done by a licensed nurse to evaluate resident ' s condition until such time the resident has been stabilized. A review of the facility ' s P&P titled, Emergency Procedure-Choking,revised on ,d+[DATE], indicated the following: For conscious resident (standing or sitting): 1. Ask the resident if he or she is choking. 2. Ask the resident to cough or speak, if at all possible, to determine if his or her airway is obstructed. 3. If able to cough, instruct and encourage the resident to continue coughing to dislodge or expel any foreign object. 4. If the resident cannot cough, only then should abdominal thrusts be performed. Repeat the thrusts until the foreign body is expelled or the resident loses consciousness. For unconscious resident (lying down): 1. Position the resident on his or her back with the arms at his or her side. 2. Proceed with CPR immediately if the resident has no pulse or respirations. A review of the facility ' s P&P titled, Emergency Procedure-Cardiopulmonary Resuscitation, revised ,d+[DATE], indicated the following: 1. Victims of cardiac arrest may initially have gasping respirations. 2. Early delivery of a shock with a defibrillator plus CPR within ,d+[DATE] minutes of collapse can further increase chances of survival. 3. Obtain and/or maintain American Red Cross or American Heart Association certification in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) for key clinical staff members who will direct resuscitative efforts, including non-licensed personnel. Emergency Procedure-Cardiopulmonary Resuscitation steps included: 1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR and instruct a staff member to retrieve the automatic external defibrillator. 2. The BLS sequence of events is referred to as C-A-B (chest compressions, airway, breathing). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A109	A. Building B. Wing	03/20/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Actual harm Residents Affected - Few	3. Chest compressions: Minimize interruptions in chest compressions. 4. Airway: Tilt head back and lift chin to clear airway. 5. Breathing: After 30 chest compressions provide 2 breaths via Ambu bag or manually (with CPR shield). 6. All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest. Trained rescuers should also provide ventilations with a compression-ventilation ratio of 30:2. 7. When the AED arrives, assess for need, and follow AED protocol as indicated. A review of the facility ' s P&P titled, Mental Health Worker, undated, indicated Mental Health Worker ' s responsibility included: respond to all facility Codes.